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ABSTRACT

This monograph is the third-year report of the Health and Education Collaboration Project (HEC), directed by the Hawaii Medical Association, whose purpose is to develop, test, and disseminate a model for family-centered, interprofessional training and service delivery. At the heart of the demonstration effort is the Healthy and Ready to Learn Center (HRTL). The Center offers family-centered services from an interprofessional and collaborative model, an emergent model of support based on the understanding that children grow up in complex environments. The report's sections are: (1) "What Is Family-Centered Interprofessional Collaboration?"; (2) "Seven Principles of Family-Centered Interprofessional Collaboration"; (3) "Health and Education Collaboration Background"; (4) "Implementation of Family-Centered Interprofessional Collaboration" (Year One, Year Two, Year Three, Health and Ready to Learn Center); (5) "Developmental Stages and Lessons Learned" (Building a Shared Vision; Staff Development; Training; Evaluation, Feedback, and Refinement; Dissemination); (6) "Implications for Future Interprofessional Collaboration Efforts"; (7) "Practice Examples of the Principles of Family-Centered Interprofessional Collaboration"; and (8) "Summary." Appendices include information on training, project updates, and project committee members. (Contains 27 references.) (EV)

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Building Bridges

Lessons Learned in Family-Centered Interprofessional Collaboration

Year Three

PS 026291

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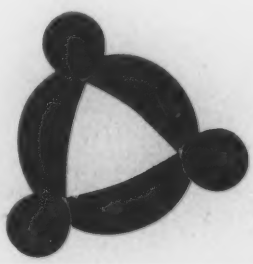
Sharon Taba
Project Director, Health and Education Collaboration Project



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Preface

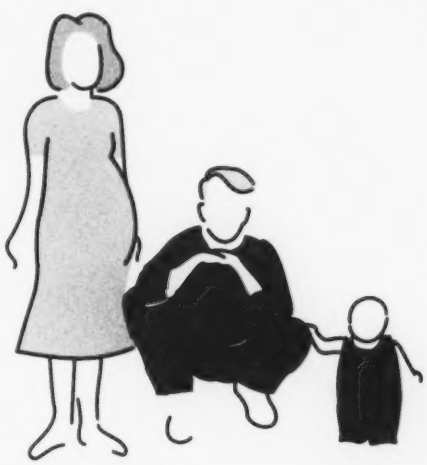
This monograph, ***Building Bridges: Lessons Learned in Family-Centered Interprofessional Collaboration, 1997***, is the Year Three report of a committed group of staff, administrators, foundations, and families working together to address health and education issues faced by children and their families and to prevent long-term, more complex problems from developing. The Health and Education Collaboration Project (HEC) is developing, testing, and disseminating a model for family-centered, interprofessional training and service delivery; it is directed by the Hawaii Medical Association (HMA). At the heart of the demonstration effort is the Healthy and Ready to Learn Center (HRTL). The Center offers family-centered services from an interprofessional and collaborative model, an emergent model of support based on the understanding that children grow up in complex environments. It is one of the nation's serious attempts to ensure healthy development through collaboration. The model calls for new working relationships among families and professionals. The goal is to improve community-based services for young children who may be most at-risk for behavioral, psychosocial, health, and educational problems.

When families thrive, communities flourish, and our nation reaps the benefits.

President William J. Clinton, 1997

It is important for health and human services practitioners and educators to consider children within their contexts. These include daily economic, geographic, political, cultural, gender, racial, social, and educational issues faced by families. Help for families is often influenced by the complex interplay of many factors such as health insurance, transportation, willingness to ask for help, trust, and understanding of how that help will benefit families.

Amid these complexities, services to children and families are often fragmented. Practitioners may be expert in their specific areas, but often they are unaware of the additional help other professionals offer. In fact, practitioners may not know the signals that indicate families may need more assistance. Professionals are also often restricted by rules and procedures, or may be territorial and unwilling to share their expertise with others. The problem of division among professionals is so serious that the HEC evaluator said, "Pervasive problems in health, education, and social services for families and children are caused, at least in part, by the isolation of professionals in categorical training and service delivery systems" (Duggan, 1997).



This monograph presents the goals, approaches, expectations, supports, and challenges of HEC during its third year (1996-1997). The monograph is the result of an ongoing grant from Maternal and Child

Health Bureau (MCHB), Title V, Special Projects of Regional and National Significance (SPRANS). The purpose of this MCHB funding initiative is threefold:

1. to demonstrate the ability of health, social service, and education professionals to work together in communities to foster successful physical, social, and emotional growth for children and their families;
2. to assist in the development of curricula based on best practices learned in community settings; and
3. to disseminate a collaborative model of personnel training and service delivery at the regional, state, and national levels.

The initiative grew out of the recommendations of Healthy People 2000 and the National Agenda for Children with Special Health Care Needs: Achieving the Goals 2000. One of the latter's objectives is to create a collaborative health, education, and human services system for children and their families, particularly those with special needs. In keeping with this national agenda, HEC is developing a personnel preparation model that promotes working relationships among trained collaborative providers and keeps families pivotal to the process (U.S. Department of Health and Human Services, 1996). Along with the HEC community-based project, two university-based programs were funded by MCHB to target university schools of social work, education, and medicine. The three demonstration projects are:

- **Health and Education Collaboration Project**, Hawaii Medical Association. Principal Investigator: Calvin Sia. Project Director: Sharon Taba. Co-Project Director: Louise Iwaishi.
- **Partnerships for Change Project**, Department of Social Work, University of Vermont. Project Director: Kathleen Kirk Bishop.
- **Higher Education Curricula for Integrated Service Providers Project**, Teaching Research Division, Western Oregon State College. Project Director: Vic Baldwin.

Philippe Gross

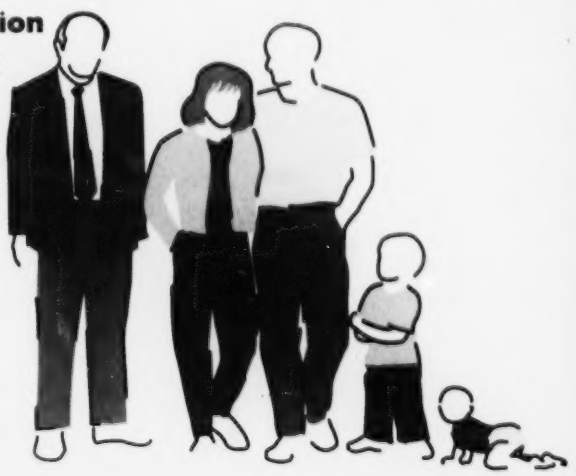
What Is Family-Centered Interprofessional Collaboration?

Family-Centered Interprofessional Collaboration is a human services approach based on the belief that professionals from diverse disciplines such as health, education, and social work can accomplish more by working in partnerships together with families than they can apart.

Family-centered care refers to the concept that recognizes and builds upon families' strengths and resiliency to meet their needs and aspirations. Family-centered practitioners respect families' history, culture, language, priorities, and practices. Family-centered practitioners also recognize that the family is the constant in their child's life, and they understand that families make the final decisions for themselves and their children.

Interprofessional collaboration refers to professionals from diverse areas of expertise working together with families to benefit children and families. Interprofessional practitioners must develop and nurture trust within their partnerships. They, too, must learn to respect one another's history, culture, language, and practices. Interprofessional collaboration is not an end in itself. It is a methodology for helping families accomplish their personal goals in comprehensive and integrated ways.

Family-centered interprofessional collaboration marries the principles of both family-centered care and interprofessional collaboration into a comprehensive approach to partnerships among families and human service professionals. It is the teamwork and care that professionals and families offer to one another that enables all to identify, understand, and reach goals that ultimately benefit children and families.



Seven Principles of Family-Centered Interprofessional Collaboration

The Health and Education Collaboration Project (HEC) has completed three years of work to develop a demonstration model of personnel preparation and service delivery that is based on family-centered values and extensive interprofessional collaboration. Students and interns at every level – from undergraduate students through medical residents – have had opportunities to learn on-site at HRTL. As part of the ongoing mission of HEC to further this effort, project staff developed a set of principles to address the needs of the families and staff. The principles are adapted from monographs developed by Kathleen Kirk Bishop, D.S.W., Josie Woll, and Polly Arango (1993) and Katharine Hooper-Briar and Hal A. Lawson (1994).

Family-Centered Interprofessional Collaboration:

1. Promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family.
2. Recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship.
3. Acknowledges that the development of trust is an integral part of the collaborative relationship.
4. Facilitates open communication so that families and professionals feel free to express themselves.
5. Creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored.
6. Recognizes that negotiation is essential in a collaborative relationship.
7. Brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

Health and Education Collaboration Background

The Health and Education Collaboration Project (HEC) was created to identify, develop, and promote key aspects of collaborative interprofessional practice and education. The community-based Healthy and Ready to Learn Center (HRTL) is the primary training site for HEC. HRTL provides direct services to families with children (prenatal to age five) who are at risk for school failure. (See page 9 for HRTL description.)

HEC partners with HRTL to assure that services are provided in the context of family-centered interprofessional collaboration. Thus, the two programs work hand-in-hand to assure that families have access to an array of services that are delivered in a caring and coordinated manner.

Developers of the collaboration first envisioned the concept for HRTL in 1992 and, for the next two years, played an integral role in seeing the concept become reality. The leadership developed the nuts and bolts of the program, which included building support for collaboration with other agencies, and initially hiring and training HRTL personnel. Under the leadership of Dr. Calvin Sia, a consortium of five primary sponsors for HRTL was convened.

Consuelo Zobel Alger Foundation. The Alger Foundation, which is the operating foundation for HRTL, manages the program. Their eight-year budget includes the cost of facilities, construction, and operations. Headquartered in Honolulu, the foundation operates 44 programs in the Philippines and five in Hawaii. Much of its work focuses on child abuse prevention and amelioration.

Hawaii Medical Association (HMA). HMA, a professional physician organization, was responsible for the initial development and administration of HRTL.

Kapiolani Medical Center for Women and Children (KMCWC). KMCWC, a teaching hospital, provides preventive health services which include physician coverage and staffing of a nurse practitioner and a medical receptionist/billing clerk. KMCWC also provides equipment and supplies for clinical services. The administrative staff and departments have donated many hours to planning and implementing these services.

University of Hawaii John A. Burns School of Medicine, Departments of Pediatrics and Obstetrics-Gynecology. The chairs of these two departments have assigned residents to HRTL for a family-centered interprofessional practicum within their clinical rotations under faculty and HRTL staff supervision.

Child and Family Service (CFS). CFS, the largest private social service agency in Hawaii, became the permanent administrative agent of HRTL in January 1997. In Fall 1997, CFS opened its first comprehensive family center on Oahu, where HRTL will be housed in the future.

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Implementation of Family-Centered Interprofessional Collaboration

Year One (1994-1995)

> **We envision communities throughout the world where families have children who are ready to maximize their learning upon entering their educational setting. By ready, we mean that children up to five years old are stimulated, mentally challenged, healthy, emotionally adjusted, and developmentally on target so that they maximize the benefits of their formal education.**
>
> HRTL Vision, Sponsors, 1995

The first year of implementation was a learning year. Identifying key elements of family-centered interprofessional collaboration changed how HRTL created new services and shared resources at the Center. This approach has much endorsement in the professional literature on support services for families with young children. People live in complex environments, and programs, professionals, and families need to collaborate with one another and the resources available to them to meet the needs of young children; to that end, needs and existing services must first be identified.

Year Two (1995-1996)

> **According to the Maternal and Child Health Bureau, children with special health care needs, particularly those with developmental delays and biological risk factors, have been identified since the 1970's. It was critical during the 1990's to add environmental risk factors [to our understanding of special needs] in order to create a preventive system of care. HEC and HRTL are models of focused prevention, intervention, and collaboration. As models they are, of course, still evolving.**
>
> Calvin C.J. Sia, Interview, 1997

During Year Two, HEC and HRTL understood more fully that partnerships among professionals and with families are desirable, but they challenge professionals:

1. To support the entire family as necessary to assure positive growth and well-being for young children; and,
2. To offer comprehensive support, knowing that families ultimately make the health, parenting, and educational decisions involving their children.

Year Three (1996-1997)

> **The collaborative process is complex. Work with our children and families is difficult. During Year Three, it appears that staff have evolved a new sense of satisfaction and job performance which includes role relinquishment and more collaboration. There has**

been refinement and interprofessional collaboration, especially in the training. With program changes planned, there will be opportunities to continue to improve program services.

Caroline Oda, Interview, 1997

In Year Three, most of the staff were employed with the program for the full year, and family-centered partnerships progressed. The staff evaluated, consolidated, and refined the HRTL programs. HRTL sponsors maintained their expenditure of time and resources to HEC and HRTL. The long-planned transition of administration of HRTL from the Hawaii Medical Association (HMA) to Child and Family Service (CFS) began. The families and staff renewed their priorities and commitment to refining their way of working together.

Healthy and Ready to Learn Center

HRTL was developed to assist families under stress in accessing services they want. The program provides collaborative health, education, and social services for pregnant women and families with children birth to age five at risk for poor health or school outcomes primarily due to negative environmental factors (e.g., teen pregnancy, poverty, substance abuse). A nurse practitioner, social worker, early educator, program director, medical receptionist, and support person form HRTL's interprofessional team. They collaborate to provide services which support the whole family in a welcoming, family-friendly cottage in a Leeward Oahu community.

HRTL services include health and developmental screening, immunization, adult education, parent support group, parenting class, play group, prenatal/postpartum care, social service and early education referral, and some transportation. Other collaborative activities include care coordination and referrals to other services, counseling and crisis intervention, and volunteer and University student training. HRTL services are integrated to maximize families' time and experiences at the Center. For example, HRTL facilitates families' transition from welfare to work: parents come to classes on welfare reform and job searching and get their TB clearance, and their children participate in play group and are immunized so they can be enrolled in preschool.

Some of HRTL's successes this year included policy and procedure development, improved intake and records management, more use of play groups as a vehicle for collaboration, recruitment of leaders from among the families for the newly-developed Parent Council, and expansion of partnerships with other community providers. In sum, family-professional partnerships at HRTL have been enhanced by the exploration and implementation of family-centered interprofessional collaboration.

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Developmental Stages and Lessons Learned

HEC and HRTL identified five stages* in the development of the HRTL model as a demonstration of a family-centered, community-based, interprofessional collaborative program.

1. **Building a Shared Vision**
2. **Staff Recruitment and Development**
3. **Training of Students**
4. **Evaluation, Feedback, and Refinement**
5. **Dissemination**

*Most of these stages occur simultaneously.

Early in the development of the program, these five stages laid the groundwork for our new approach to service integration. As the program has grown, participants have revisited the stages, learning new lessons.

These five stages of program development theoretically model other types of development, with growth spurts and plateaus, difficulties encountered, and varying intensity and duration of the stages. Just as children grow, each stage is vital to the growth of the others. If one stage is changed, the others will feel the change as well. Embedding a shared vision into the program's values, mission, goals, and objectives is essential to making it a reality. All those involved – families, staff, and sponsors – should agree on steps to take to develop a cohesive program, recognizing that change and adaptation are necessary to program development. Staff recruitment and development should be based on the shared vision, with the expectations that 1) professionals are committed to family-centered collaboration and the extra time it entails, and 2) leadership will provide support and training for staff to deal with the unique challenges of collaboration. Pre- and in-service development of staff can keep the program moving, especially with staff turnover and the emergent needs of families involved. Training of students, using HRTL as an on-site, hands-on resource for education, helps to socialize a new generation of professionals with experience and understanding of a professional and collaborative model. Evaluation, feedback, and refinement are integral to improving staff, student, and family partnerships. The last stage, dissemination, shares the lessons learned in a collaborative model. These lessons contribute to national efforts to improve outcomes for families at-risk, encourage philanthropic support, and help communities to support families as they learn to trust and use the programs, which, at the same time, learn to collaborate with families.

Stage 1: Building a Shared Vision

Shared vision is vital for the learning organization because it provides focus and energy for learning.

Senge, 1990

HRTL is a demonstration model. Its mission offers many challenges and opportunities for family-centered interprofessional collaboration. HRTL's development is a never-ending process. It is also expensive and difficult to provide appropriate programs for families with special needs. To meet the challenges and achieve their mission, the HRTL team worked diligently during Year Three. They learned many lessons about building and operationalizing a shared vision which may be encapsulated in these four:

- **Stay focused.**
- **Strengthen trusting relationships within and across community networks.**
- **Clarify choices for support with families.**
- **Teams are the core of family-centered inter-professional collaboration for families with young children.**

Lesson 1: Stay Focused.

Emerging visions can also die because people get overwhelmed by the demands of current reality and lose their focus on the vision.

Senge, 1990

With a large, complex mission, it is critical to stay focused. When part of that mission is to achieve family-centered interprofessional collaboration, coming together with each family as a touch point for service helps to assure necessary focus. There are many facets of family service: early identification of special needs, provision and integration of service, linkage to other programs, and collaboration with families and other professionals. At HRTL, these all occur with a focus on one family at a time. This work, which in the first two monographs was identified as "starting small," is a viable way to provide family-centered help within a systems model. Each family – and each individual within a family – becomes a focal point for service in his or her own complex environment. At HRTL, that focus allows families, staff, and sponsors to keep their eyes on their shared vision, which is communities in which all children are healthy and ready to learn when they enter school.

What is the mission of the HRTL collaborative?

- Identify families with potential special needs with (or soon to have) infants, toddlers, and preschool children.
- Provide and integrate health, education, and human services for families with high risk, preschool children.
- Integrate with other existing programs as necessary; develop programs if needed while avoiding duplication of, and competition with, these programs.
- Provide collaboration among professionals of health, education, and human services in applying the holistic preventive approach for family wellness.
- Assure that this collaborative, integrated system of care is institutionalized in Hawaii by the year 2002.
- Assure the sustainability and replication of the HRTL program.
- Advocate a collaborative, integrated system of care.

HRTL, 1997

The journey of 1,000 miles starts with a single step.

Lao-Tzu

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A vision can die if people forget their connection to one another. . . The spirit of connection is fragile. It is undermined whenever we lose respect for one another and each other's views.

Senge, 1990

Lesson 2: Strengthen trusting relationships within and across community networks.

> **We've got to put our brains together, prioritize our own duties, and figure out ways to help others. Collaboration means many things to many people and seems to work best when we keep journals and calendars and allow time to plan service and provide feedback. We also need leadership. Most of all, we have learned that our own work is enhanced by work with others.**
>
> Joni Choi, Interview, 1997

Interviews with staff at HRTL provided information on ways in which trust and respect are built with families and among staff. As Joni Choi, the HRTL support staff person, said, "Collaboration only works when a person is willing to listen" (Joni Choi, Interview, 1997). She and Blanche Butler, the HRTL medical receptionist, stressed the importance of regular schedules, accessible staff, a relaxed, home-like environment, and the use of HRTL as a "home base" for families needing multiple services. Blanche also articulated the need for emotional support.

> **HRTL does a good job of regularly telling our families what they are doing well. We should not underestimate our families just because they are poor! I just tell them what is available, and we try not to push everything all at once. I let them know that their file and the van are both open whenever they need care.**
>
> Blanche Butler, Interview, 1997

HRTL continues to develop community awareness and partnerships with families through strategies such as displays at shopping malls, visits to churches and community programs, and meetings with families who "stop by" the Center. Committed to strengthening community relationships, Dolores Brockman and Sharon Taba of HEC worked on linkages between HEC and HRTL staff and University faculty. Audrey Ching, the HRTL program director, developed outreach and collegial interaction with receptive community agencies. Lisa Carlson, the HRTL early childhood educator, described some of the HRTL team's efforts in this area:

> **We are working hard at becoming more involved with community groups. Our efforts have included volunteering at health fairs, keiki play mornings, and neighborhood task force activities. We want to become more of a presence with HAEYC (The Hawaii Association for the Education of Young Children). We also work with the local hospitals and with special education providers. Balancing our time in the community and the push-pull pressure of direct services to families is always an issue for us. However, to move into prevention, our program must work collaboratively with other service providers in the community.**
>
> Lisa Carlson, Interview, 1997

In Year Three, the HRTL team focused on their relationships with other community providers serving their families, such as the Waipahu Ohana Center, Queen Liliuokalani Children's Center, Healthy Start, Public Health Nursing, and Rural Oahu Family Planning.

Philippe Gross

Also at the community level, programs such as Malama Na Wahine Hapai, a prenatal home visiting project, teach the HRTL team to reach families in culturally competent ways. In Malama, neighborhood women do home visits and joint home visits with other agencies, make telephone calls, and work with lay professionals (like Joni and Blanche). They provide families with food coupons donated by neighborhood businesses, and they use interpreters for languages such as sign, Ilocano, and Tagalog.

In summary, collaboration is built by strengthening trusting relationships at many levels of involvement: the family, staff, community, and policy (which is especially important to secure financing and make policy decisions) levels. Comfortable "connections" developed among programs, providers, and families take the shared vision beyond the walls of one program into the community which it serves.

Lesson 3: Clarify choices for support with families.

> **As clarity about the nature of the vision increases, so does awareness of the gap between the vision and current reality. People become disheartened, uncertain, or even cynical, leading to a decline in enthusiasm.**
>
> Senge, 1990

New kinds of support may confuse families familiar with traditional helpers. The question, "Does the interprofessional model confuse families?" brought the most varied responses from HRTL staff, families, and administration. Most participants thought that the program was not confusing for family members. The cozy atmosphere of the Center and the presence of a small, diverse staff seemed to dispel much anticipated confusion and actually reassured some families. (See Practice Examples presented later in this monograph.) Those who thought that there was some confusion for families identified the differences in staff personalities and communication styles which occur in any human service program as the source of that confusion. In fact, recognizing and respecting divergent personalities and communication styles emerged as a theme.

To work best as a team, we need to keep developing skills to communicate, articulate, confront, commit, and to live through each family's experience as a team. . . . We will never be finished – collaboration is ongoing, and we are the bridges.

Mel Hayase, Interview, 1997

There has also been staff turnover at HRTL, again as there always is in human service programs. Consistent staff practices helped to keep families informed. During the next year, emergent collaborative partnerships will include families involved in creating a Parent Council with the administration of CFS, HEC, and the Alger Foundation to further elucidate the program with families. This reciprocal process will create a forum for families to build upon and share the vision of HRTL to address the "gap between the vision and current reality."

Lesson 4: Teams are the core of family-centered interprofessional collaboration for families with young children.

> **With a shared vision, we are more likely to expose our ways of thinking, give up deeply held views, and recognize personal and organizational shortcomings.**
>
> Senge, 1990

Teamwork is the core of interprofessional collaboration, and it is often the most difficult to establish. There are many levels of team effort at HRTL – sponsors, families, staff and students from their varied disciplines, and other community agents – responsible for many aspects of the program – program development, service delivery, training, and outreach. Audrey Ching, HRTL director this year, said of the teamwork:

> **We now work as a very close, interpretive, collaborative team, but it's not easy because we had to invent it [cohesiveness] along the way. Each of us has our own energy level, communication style, time table, expectations, and level of tolerance for ambiguity. Politics and economic elements are a constant 'reality check.' And collaboration at one level should be supported by all the other levels. Ultimately, we want to evolve, grow, and be responsive as a program serving families.**
>
> Audrey Ching, Interview, 1997

Stage 2: Staff Development

Ongoing support for staff development is necessary for interprofessional collaboration. Staff training can take many forms. Good communication and negotiation skills and willingness to listen, learn, and participate are necessary among staff. The establishment of clear roles and leadership help make a family service program more effective.

This year, HEC and HRTL identified four lessons in staff development:

- **True leaders follow the families' lead and help administration follow.**
- **Refine skills in the collaborative process.**
- **Communication is key to collaboration.**
- **Continue staff development in work with children and families.**

The importance of time efficiency, accountability, goal accomplishment, and cost effectiveness which drive programs such as HRTL are infused throughout the lessons in staff development. The continued focus on the strengths and priorities of each family and the program mission also remains essential to daily work.

Lesson 1: True leaders follow the families' lead and help administration follow.

The collaborative process does not mean that all people are equal in all tasks at all times. Clear delineation of roles and a focus on outcomes enable members of a team to learn to lead and to be led at appropriate times. The vital importance of leadership and clearly-defined roles cannot be overstated. Leaders help collaborative teams stay focused. Leaders can also serve as advocates for families. For example, families at HRTL were asked if they wanted to form a volunteer Parent Council to speak with the staff and administration on the families' behalf.

At HRTL, it was determined that that there should be one strong team member, probably the program director, who has the job of keeping the team focused, setting the program and direction with the team, mediating issues among program and staff, and making the final decisions on personnel, facility, program, and partnerships. The director should be flexible, listen to what the staff has to say, and serve as an advocate for the many facets of the program. The leader must learn from other staff and families, clearly articulate their integrated voice, and then translate that integrated voice into policy. The leader

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is responsible for calling meetings, coordinating administration and staff efforts, and supporting people at the Center. Thus, the leader's role is one of support and facilitation as much as one of guidance.

The exchange of roles between leader and staff – crucial to interprofessional staff development – should also be fluid. As an evolving leader, one serves as a river, not a dam, letting the process flow between and around the big rocks (Coit, 1997). There are many opportunities for staff and families to assume leadership roles. Ultimately, families must lead the program, and staff and administrators must follow with responsive policy and procedures for high quality services.

Lesson 2: Refine skills in the collaborative process.

The HRTL model of collaboration, particularly between medical and other human service professionals, is a demonstration model still in its early stages (Calvin Sia, Interview, 1997). As Dunst et. al. explain (1995), much human service work is modeled after a traditional medical model in which individuals are not understood in a systems context, but are seen one at a time in a clinical setting. With the concept of a "medical home" for children and families, physicians are encouraged to collaborate with other professionals. A medical home is described by the American Academy of Pediatrics (AAP) as being "accessible, continuous, comprehensive, family-centered, coordinated, and compassionate" care for children and families, facilitated by well-trained physicians working within the families' communities (Ad Hoc Task Force on the Definition of Medical Home, 1992). This exciting approach to care acknowledges the need for family-centered interprofessional collaboration to best serve children and families. Recently, Rob Welch, president of Child and Family Service (CFS), emphasized the importance of this model:

> **We've learned a lot about interprofessional collaboration. One thing which excites me about the HRTL Center is the opportunity for social service and early childhood educators to work with medical services in order to help children become healthy and ready to learn. This will result in a gain for the whole community.**
>
> Rob Welch, Interview, 1997

This year, HRTL staff went beyond teaching each other what they were doing and why (Building Bridges, Year Two, 1996) to actively cross-training. Several staff members said that it is presently difficult to describe individual positions within the HRTL team because they collaborate to the extent that they can

perform some of each other's duties, and some duties may even overlap. With disciplines as divergent as health, education, and social service, this level of interprofessional competence is a particularly impressive achievement. In issues regarding legality, safety, or accreditation – particularly medical or social work issues – there is more clear definition. As Mel Hayase, HRTL social worker, said, he is most likely to pull back into his "official social work shell" when "there is an issue involving legal limits and protection" (Mel Hayase, Interview, 1997).

At HRTL, the current intake process (by which families enter the program) is a skilled process in which families and staff plan their work together. During intake, staff may begin interacting in more traditional (discipline-based) roles at first, then move into more collaborative styles as they and the families bond. The staff member most closely bonded to each family should be the one to serve as the care coordinator for that family, leading the collaborative process and working closely with the family over time.

For staff, viewing families as partners in the collaborative process develops skill in helping families ask for information, clarification, and further resources. Training each other, helping families and the community learn to work better together, and reaching out for self-improvement are all part of refining collaborative skills. This is an area in which HEC and HRTL have truly developed . . .

> **. . . different paradigms for coming together. This is not easy stuff . . . It is difficult to think systemically and to think of people in their contexts. We tend to be linear (based on a traditional 'disease model' from medicine), and our treatment teams need to look at the relationships between nutrition, health, and disease from a family system perspective.**
>
> Rob Welch, Interview, 1997

The new "journey" or process of collaboration is multi-dimensional. The process involves many personal and interpersonal skills, from self-reflection to listening and integrating diverse perspectives.

Lesson 3: Communication is key to collaboration.

> **Good communication is the foundation of effective working relationships. Seeking to understand and learning to listen are vital communication skills.**
>
> **Human responses, like resentment, suspicion, vulnerability, and rigidity, can interfere with interprofessional collaboration. Acknowledging these responses is the first step in learning to deal with them.**
>
> **What people say to each other and how they say it can have a profound impact on a collaborative relationship.**

In interprofessional collaboration, it is important for all professionals involved to identify and acknowledge their expectations of themselves and others so that other professionals can support them or work with them to determine more realistic expectations.

Iwaishi, Taba, Brockman, Howard-Jones, Ambrose, In Press

These excerpts from HEC's *Training on Family-Centered Interprofessional Collaboration* (In Press) aptly summarize some key issues in collaborative, family-centered communication. It is often miscommunication that highlights the need to focus on and nurture this central aspect of collaboration among all levels of a program. With the importance of ongoing work with families and young children and the transitions faced by the program, HRTL staff, sponsors, families, trainees, and the surrounding community must develop "skilled discussion" (find common solutions by uncovering divergent assumptions and biases) (Senge, 1990).

In Year Three, HRTL worked closely with the sponsoring partners. As Caroline Oda, representing the Alger Foundation, said,

I try to visit the HRTL Center at least once a week in order to stay in touch with the program, staff, and families. I have noticed with staff that simply being there and being accessible aids the communication with families and builds trust.

Caroline Oda, Interview, 1997

This year, new lines of communication were established with Child and Family Service (CFS). In January 1997, CFS assumed administrative responsibility for HRTL, and partnerships for ongoing program development continued.

Lesson 4: Continue staff development in work with children and families.

Learning is a life-long, dynamic process for families, children, students, and professionals alike. The concepts of family-centered care, interprofessional collaboration, and the medical home – all of which are evolving with the human service environment (in terms of societal developments such as managed care, welfare reform, and research on brain development) – require ongoing work. Competence in work with children and families takes years to achieve. Vicki Wallach, Acting CFS Administrator of HRTL, said:

I try to learn from everyone and everything around me. As professionals, I believe it is important to continue to develop ourselves. To support this growth, I hope HRTL can create an ongoing learning environment through peer mentorship and staff training opportunities. Since we work with very young children, the goal is to be as skilled and as sensitive to family needs as possible so the infants and toddlers in our program can maximize their development.

Vicki Wallach, Interview, 1997

Stage 3: Training

During Year Three, we did good work through HEC and HRTL; we focused on the resident training. We developed a manual and provided hands-on training, which is so important for staff and medical residents. I am sure training will continue since it provides a form of support, creates energy at the site, and has been implemented in a way that does not bog down staff or take away from our service to families.

Dolores Brockman, Interview, 1997

This year, HEC and HRTL – with Kapiolani Medical Center for Women and Children and selected programs of the University of Hawaii at Manoa (UHM) and the University of Phoenix (UP) – further developed their family-centered interprofessional training for 1) pediatric residents, 2) graduate students from UHM Schools of Social Work and Public Health, and 3) undergraduate students from UHM College of Tropical Agriculture and Human Resources (family resources) and UP nursing program. Twenty-three students received on-site training at HRTL. Lessons learned in training during Year Three included:

- **Keep the rich opportunities for training in community programs.**
- **Use the lessons students and family members teach us.**

Lesson 1: Keep the rich opportunities for training in community programs.

Some of the [pediatric] residents have been very committed to the interprofessional basis of HRTL, and others still have difficulty seeing the value of the team. The rotation experience has been rich in addition to the curriculum because it has given residents time to spend with a family and a more holistic view of the needs and concerns of a family. Residents have been able to view the family in a more nurturing context. They have also seen the difficulty and process of team growth.

Louise Iwaishi, 1995

Training on family-centered interprofessional collaboration should involve formal and informal, self-directed and program-sponsored, pre- and in-service training for staff, students, and families. It should look at the basic application principles of the disciplines represented (at HRTL, social work, early childhood education, nursing, pediatrics, and obstetrics-gynecology) as an introduction which is then reinforced through discussions and interactions among team members and families.

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We meet because people holding different jobs have to cooperate to get a specific job done. We meet because the knowledge and experience needed in a specific situation are not available in one head.

Peter Drucker

HRTL staff have learned to train each other, other professionals, and community members. Families have been included in on-site training more than in previous years. As one mother said, "I have learned to speak out and ask for things. One idea I had even turned into a workshop for other families. The Mixed Plate* is a very helpful way for us families to be active and to learn more."

Practica supervised by staff provide opportunities for both students and staff to become more comfortable with the practice of family-centered interprofessional collaboration. Classes for parents taught by residents enhance the residents' understanding of families as much as they address the questions and interests of parents. In these ways, "real world," on-site training enriches services for families and student experiences at HRTL.

Lesson 2: Use the lessons students and family members teach us.

> **Health care service is changing. We are all interdependent now, and collaborating is difficult. Pediatricians have to work in partnership with the Department of Health, Shriners [Hospital for Children], the medical school, and the whole University. We are striving to preserve the medical home and to curb corporate steerage of health care. The gap between what insurance will pay for and what families need is huge, and professionals are caught in the gap.**
>
> Louise Iwaishi, 1996

To develop a new generation of physicians, social workers, and early childhood professionals practicing family-centered care, students and professionals must really listen to what families have to say. Interviews, informal conversation ("talking story" together), and formal classes and group support sessions all provide means for families, staff, and students to learn from each other. As Sharon Taba explained,

> **We are changing practice for professionals and for families in a gentle, respectful way, using demonstration and mentoring. Residents are learning to interview and to teach parenting, and they are also learning to listen and to take their lead from our families.**
>
> Sharon Taba, Interview, 1997

This is how advocacy begins.

*Mixed Plate is an HRTL activity which combines parent classes co-taught by the nurse practitioner, social worker, and, recently, by pediatric residents with early childhood activities for children.

Stage 4: Evaluation, Feedback, and Refinement

Honest criticism is hard to take—particularly from a relative, a friend, an acquaintance, or a stranger.

Anonymous, found in Briggs, 1997

Effective collaborative teamwork depends on evaluation, feedback, consideration of results, discussion, and efforts to refine programs based on lessons learned. HEC and HRTL have used evaluation information to propose and make program changes with the assistance of professional evaluators – Dr. Mike Heim, Hawaii State Department of Education, Dr. Anne Duggan, Johns Hopkins' Children's Center, and Dr. Robert Heath, University of Hawaii School of Public Health – led by HMA.

To date, the purpose of evaluation has been formative; that is, it serves to provide information which can describe the HEC and HRTL programs to date and inform their future development (Duggan, 1997). In the future, evaluation will become both summative and outcomes-based. Since the work described in the monograph demonstrates a complex interprofessional model, the evaluative components are very important for staff, funding partners, administration, and, ultimately, for the children and families involved.

During Year Three, evaluators conducted site visits, met with HEC leadership, interviewed staff and social work and nursing students, and led focus groups with pediatric residents. Interviews focused on definitions of interprofessional collaboration, barriers to and incentives for involvement, lessons learned, and students' perspectives about the work of the programs.

Some of the valuable lessons learned about evaluation, feedback, and refinement include:

- **Seek evaluation and feedback at all levels of program service.**
- **Develop multilevel commitment to outcomes and the evaluation process.**

Lesson 1: Seek evaluation and feedback at all levels of program service.

Evaluation should be part of the ongoing, daily agenda of a program, not something brought in at the end. Effective evaluation of collaboration must gather feedback from many program levels – families, communities, administration, staff, and students – and that feedback must be incorporated into program. Moreover, regular opportunities to give and receive formal and informal feedback are essential to staff development. Involving families in

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evaluation efforts which lead to service refinement may increase family investment in the program. The leader (e.g., the program director) plays a vital role in generating staff and family enthusiasm for healthy evaluation that will ultimately strengthen all aspects of a human service program.

HEC and HRTL staff attempted to obtain and incorporate these levels of feedback in Year Three. They became more confident in using evaluation and refining programs based on those tools. In fact, because such progress was made in this area, staff asked for more training on identifying outcomes. Means for feedback are continually being developed. Staff also provide each other with support and feedback; for example, this year HEC videotaped the HRTL staff training students and offered those videos to them for critical review.

Lesson 2: Develop multilevel commitment to outcomes and the evaluation process.

The call for "results-based" or "outcome-based" accountability abounds in current evaluation literature. For HRTL, the primary challenges of this call are 1) meeting the expectation of funders for "'returns on investment' measured against future outcomes and their costs and benefits to society" (Schorr, 1995) and 2) accommodating both process accountability (short term) and outcomes accountability (long term).

Current and potential funders understandably expect a return on their investments. This expectation engenders certain risks of evaluation that loom largely over the staff and directors. The risks are challenging for HRTL, particularly when evaluation recommends better data collection before program refinement can be addressed. Critical incidents that reflect positive outcomes can be difficult to document. The coordination of services for a string of five to eight families sometimes comes and goes in one phone call; stopping to document situations in progress notes impinges on program flow. Moreover, extricating critical incidents for data collection is extremely time consuming. Funders should understand these complexities and value activities that are not so easily collected or measured.

HRTL staff have attested to the dilemma between the known difficulties of documenting critical incidents and sponsors' need for quantifiable service data. These critical incidents may later prove to have profoundly affected families' outcomes. Although HRTL had the technological capacity, staff was unable to demonstrate the cumulative effect of these critical incidents on families because evaluation design did not incorporate critical incidents and statistics into data collection.

Another challenge for results-based accountability is separating or jointly evaluating the long-term, complex impact of the continuum of community

services and supports for families across domains and the life span. HRTL is beginning to learn that the schools' abilities to be ready for the children HRTL serves may have a profound influence on school readiness outcomes. Currently, HRTL has no influence on the readiness of schools for children and families receiving HRTL service.

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At HRTL, interprofessional activities such as Mixed Plate and the play group-enhanced ob-gyn clinic make identifying quantifiable measures a challenge for staff. Support activities such as the social worker's parent groups, the nurse practitioner's care plan, and the early childhood educator's one-on-one education sessions on positive child development with parents are included in these larger program activities. How each component impacts families' outcomes has not yet been determined; assessing their results remains the greatest challenge of the HRTL evaluation. Lastly, agencies and funders must understand the intricacies of quantifying those activities and be willing to invest more resources if programs like HRTL are to make an impact on successful outcomes for children and families.

Stage 5: Dissemination

Good work needs to be shared so that other programs and families may benefit from lessons learned. For HEC and HRTL, Year Three was a time for learning to share and for developing skills in organizing, adapting, presenting, and otherwise disseminating their good work. It was a time when HRTL saw the fruits of their work with other agencies and with families in their program. Three lessons learned in this stage were:

- **Target audiences committed to young children and families.**
- **Move towards the development and record of good interprofessional practices which can be applied to other programs and training.**
- **Establish an institutional and system-wide commitment to integrated service delivery.**

Lesson 1: Target audiences committed to young children and families.

Awareness of an audience and skill in communicating with people are necessary for creating change in health, education, and social service systems. Service providers as well as faculty and students touch families who, in turn, trust and appreciate providers. Family trust and appreciation are endorsements of good programs that amplify programs' benefits in their communities. This mutual giving that is the basis of good community programs is the cornerstone of dissemination efforts.

This year, HEC staff selected "audiences" interested in collaboration on behalf of young children and their families: parents with young children, university faculty and students from several fields, practitioners, policy makers, and funding partners. Selection of these audiences was based on assumptions about the future: 1) Parents and young children will be the consumers to advocate for change in service delivery. 2) University faculty can change the preparation of students who will become service providers and be in pivotal positions to change the status quo. 3) Practitioners can effect change for those who believe that successful outcomes start prenatally and in the first critical years of life. 4) Policy makers who are committed to children and who use effective collaborative strategies will develop child-friendly policy. 5) Funding partners, convinced that good investments in children and their families will be cost-saving, will look for agencies with successful collaborative track records.

Every year, HEC takes training materials and lessons learned to the National Commission on Leadership in Interprofessional Education (NCLIE, established

in 1992). NCLIE meetings are held in conjunction with conferences of national professional associations, such as the American Academy of Pediatrics (AAP), International Parent-to-Parent, or Association for Teacher Educators. This year was especially significant because selected NCLIE members were asked to review the completed draft of *Training on Family-Centered Interprofessional Collaboration* (In Press), which has also been reviewed by HRTL staff, UH faculty, and the HEC Project Advisory Committee. NCLIE member reviews have been completed as the final step before HEC disseminates those training materials to a broader University audience.

Other dissemination to University audiences was through national newsletter articles in *Partnerships for Change Information Exchange* (Winter 1996, University of Vermont), and *Service Bridges: Higher Education Curricula for Integrated Service Providers*, (Fall 1996, Western Oregon State College) and a report presented by George Washington University Center for Policy Research (1996) on current approaches for changing health care systems.

Also, HEC has actively disseminated information to prominent national audiences. These are diverse groups that promote collaborative work in early childhood and health, such as AAP chapters, Starting Points grantees of the Carnegie Corporation of New York (a network of 16 states and cities), and the CATCH facilitators and Medical Home Program of the AAP (a network of pediatricians representing regions and communities across the country). Clearly, the program has evoked a national response.

There are those of us who believe that very early experiences are of vital importance to an individual's development. When we try to convince others of the importance of these years, one of the hurdles we face is our inability to portray convincing case histories that penetrate the consciousness of the audiences.

Harris, 1996

Lesson 2: Move towards the development and record of good interprofessional practices which can be applied to other programs and training.

This year, HEC and HRTL have come to a better understanding of how families respond to services. Staff and sponsors ask for families' time, use their experience with their own children and families, and are really learning to listen to them. These can be helpful strategies in promoting collaborative services. It takes time and effort to create institutional commitment to new methods of working with families and young children at risk.

The program was developed to provide staff with opportunities to test strategies that would best suit individual families. For example, staff initially began welcoming families as a group; however, this proved too overwhelming for families. Next, staff elected the social worker to welcome families; however, this process became too discipline-specific. Finally, staff extended the time with families by inviting them to the activities offered and "talking story" with them. The staff learned that this practice of building relationships allowed time for families to feel comfortable and secure while balancing the professional-specific practice of getting social history, medical history, and child development information.

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HRTL staff worked closely on developing protocol and procedures in the following areas: intake, progress notes, family plan, data collection, and care coordination. This process raised many issues, including the following:

- How do we establish a commitment from the professionals involved to come together as a group to develop family-centered policies?
- How do we decide which collaborative practices are important?
- How will decisions be made?
- How do we learn from families and record information in family-friendly terms?

Lesson 3: Establish an institutional and system commitment for integrated service delivery.

Significant changes in the way institutions do business, especially in sharing authority and resources, will enable them to respond in a timely and able way to programs, staff, and families.

Focusing on services that are family-friendly, comprehensive, and results-based (Nelson, 1993), institutions can learn from community collaborative projects like HRTL. HRTL staff have uncovered many barriers that families face. The major challenge for staff is responding programatically to rapid and intense changes in families' needs. The interprofessional team must be able to account for the "range of needs within a family, to respond in ways that are comprehensive as well as tailored to individual circumstances, and to adjust services as families' needs change" (Nelson, 1993). They must also consider the system's ability to respond.

Even on a small scale, despite good intentions to share authority among HRTL sponsoring agencies, their differing values, beliefs, and missions have placed the HRTL team in the middle of small scale institutional conflict at its worst. At best, sponsors could serve as "kind of a court of appeals for resolving problems among and between staff and families . . . at the front line" (Nelson, 1983). Commitments of sponsoring agencies must be explicit and consistent in guiding the direction of HRTL.

Resource allocation must also be explicit. Shared decision-making regarding use of resources in a common budget is based on trusting, open, honest communication. Such shared resource allocation can be fraught with conflicting agendas and different approaches to services. Without it, the partner that provides the largest financial resource often has the "final say" and must responsibly justify such a large allocation to its own board.

The range of collaborative partners should reflect the diversity of the kinds of services they will provide. However, this diversity lends itself to disagreement regarding provision of quality integrated services. Commitment to shared authority and resource allocation and appropriate diversity of partners are the critical conditions with which collaborative partnerships must begin. Improved outcomes for children and families must be the ultimate goal for cost-effective integrated services. Lisbeth Schorr's work on results-based accountability (1995) suggests that collaboration can best begin by asking the question: "What do we want for our children?" Communicating this drive for results will broaden commitment of all child-serving agencies, institutions, and foundations. In this way, dissemination builds shared vision; it both completes and begins again the circle of the family-centered, collaborative approach toward better integrated family services.

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Implications for Future Interprofessional Collaboration Efforts

As demonstration projects, HEC and HRTL have produced both services with families and lessons for future interprofessional collaborations. The lessons learned could be very valuable:

- They can be used to better serve families.
- They can be used by administrators to develop goals and evaluation of program.
- They can be used for pre-service and ongoing training of staff.
- They form a valuable information base for research on interdisciplinary efforts.

A review of the lessons learned offer practical suggestions for service, training, community outreach, and dissemination to improve services for children and families at environmental risk.

Service

- Develop and implement accountability measures.
- Base service on the development of protocols, standards, and a core of practices.
- Co-locate services based on the medical home model to begin service integration.
- Reach out to families including follow up phone calls and home visits.
- Use sensitive cultural interpreters, from lay professionals and support staff to University-trained professionals.
- Use therapists on teams to help make mental health referrals.
- Consider sustainability.

Training

- Build training on emerging service models.
- Use staff to conduct training.
- Develop pre- and post-tests for training.
- Incorporate community and family visits into student training.
- Develop teaching and site standards.
- Demonstrate medical home training on the spot with a focus on prevention.
- Incorporate "teachable moments" or guided reflection – including input from families – while working with children and families.

Community Outreach

- Conduct focus groups regularly as community and family "temperature" satisfaction checks.
- Convene the most involved community providers, residents, and policy makers.
- Tailor programs around communities' identified strengths and capacities.
- Develop culturally attractive outreach which respects needs of families.

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Dissemination

- Emphasize the importance of human connection.
- Emphasize the importance of trust.
- Communicate constantly – listen and be open, honest, and non-judgmental.
- Seek elevated levels of self-awareness.
- Be willing to take risks.
- Enlist commitment of collaborative leadership from administration, staff, and families.
- Build a shared conceptual model which involves community resident commitment to policy, to articulation of the importance of early childhood education and services (including the medical home), to evaluation, and to the constant evolution of programs responding to individual and community self-identified needs.

Practice Examples of the Principles of Family-Centered Interprofessional Collaboration

Seven practice examples are presented here to illustrate the principles of family-centered interprofessional collaboration (from page 6). The gap between principles and practice can be difficult to bridge. Therefore, HEC asked the interprofessional staff at Healthy and Ready to Learn Center (HRTL), our training and program development site, to provide practice examples that reflect the meaning of these principles in their work with families.

Some people think family-centered interprofessional collaboration is a good idea. They believe it is an approach that enables families and professionals to negotiate the best services for children. Others are skeptical. They believe it is an approach that hinders both family and professional members because it involves too many people and requires too much time. The following examples illustrate our understanding of the principles and assert that family-centered interprofessional collaboration does indeed improve services to children and families.

HRTL joined the Waipahu Ohana Center, a nearby community school-based partnership. The founding partners were Waipahu Elementary School, the Young Men's Christian Association (YMCA), and Hawaiian Electric Company; they got their start from a City in the School Partnership national initiative. Among the many activities from which HRTL families benefited was one program which particularly reflected true family-centered collaboration – working together with a spirit of reaching out to meet families' requests, commitment of volunteer time, and limited funding.

The Malama Ohana is the parent education program that was created purely in response to families' requests for parent education. This partnership of six agencies and social work practicum students from the University of Hawaii developed a weekly, fifteen-week family education program consisting of a hosted dinner, large group activities designed to strengthen families, small group education classes for parents, older children, younger children, and infants/toddlers, and a family camp experience. Referrals were generated by all the agency partners. HRTL invited interested families to participate in the planning.

The program used the curriculum, *Nurturing Program* (1988), developed by Stephen I. Bavolek and Christine Comstock.

If anything could be said of the partnership, it was that the professional and lay professional staff, who had diverse backgrounds yet an uncanny sense of compatibility, worked ideally together. There was leadership, but no one "bossed" anyone. There was commitment, but no one was made to feel guilty for taking off a week or so. The relationship among the staff "facilitators" was collegial and offered comraderie unlike anything that the group members had previously experienced. The partnership came about naturally but purposefully, and as it nurtured and supported families, it also nurtured itself through humor and respect among staff for each other as people rather than for titles or roles.

This program not only accomplished interagency coordination but also was successful in that professionals worked together to reach their shared goal – being responsive to the child and family requests for services. The program certainly reflected the tenor of the HRTL approach. It was the seed of a unique partnership of individuals and agencies, and it blossomed within this community.

Principle #1:

Family-centered interprofessional collaboration promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family.

This example illustrates people working in harmony to coordinate their agency services with families.

(Contributed by Melvin Hayase, the social worker at HRTL.)

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Principle #2: Family-centered interprofessional collaboration recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship.

This example illustrates the challenges identified by hearing-impaired parents raising a hearing child and the responses of professionals to help those parents meet their challenges.

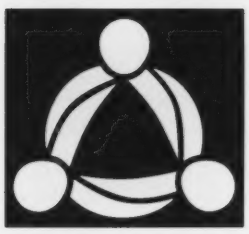
(Contributed by Lisa Carlson, the early childhood educator at HRTL.)

HRTL was contacted by a Public Health Nurse (PHN) for assistance with a family whose child needed exposure to other children and to language stimulation. The child, Jim, was one year old, and both of his parents were hearing-impaired. The child had limited opportunities to hear and to use speech. Most of his exposure to language had been through children's videos purchased by his parents. A developmental screening determined that he was delayed in communication. Clearly, this family was eligible for services. To help the family receive services, the PHN invited HRTL to participate in the development of an Individual Family Support Plan (IFSP) with Jim's family.

The IFSP meeting was attended by professionals from the Zero-to-Three Hawaii Project (Part H agency), a community respite program, HRTL, the PHN, both parents, and the child. A sign language interpreter attended the meeting to facilitate active family participation. The PHN convened the meeting, asking the family first to discuss their concerns for their family and for themselves. As each concern was identified, the parents and other team members discussed possibilities for addressing that concern. All members of the team provided information on what services they could offer and how the family could be involved. Throughout this process, the family freely selected or declined suggestions as they were offered.

One specific concern identified by the family was Jim's learning to talk. All team members offered their suggestions, and the family discussed several concerns. They decided to begin participation with the HRTL play group on Mondays. The father would attend the group with his son, as the mother worked full-time during the day. He would also take his son to the respite program on Tuesdays for language opportunities and additional exposure to other children. The mother discussed with the team how she also could become more actively involved with her son. The Zero-to-Three Hawaii Project offered to provide a home visitor who would provide services on Saturdays when the mother was home. The PHN offered to schedule some of her visits during time when the mother was at home, too. To help the mother know what was occurring during other activities, HRTL and the respite program agreed to use a communication book. Messages would also be sent to her via the fax machine and the GTE operator.

As a result of collaboration between the family and professionals who recognized and respected the family's needs, the group developed a plan that was sensitive to the rhythm of the family's routines – with convenient appointments, visits at home, and accessible play groups.



Natalie's family came to HRTL through a referral by a Public Health Nurse. She had a three year-old daughter with developmental delays in language and socialization. Natalie, the young mother, was single and pregnant; her ten-year-old son was picked up for school truancy, and her two-year-old son showed signs of developmental delay. Once homeless, at the time she came to HRTL, Natalie lived with the father of her unborn child. She had a variety of agencies working with her and her family at different times; she used their services as needed.

At HRTL, Natalie's trust in the program and staff developed slowly. When she began participating in support groups, play groups, and parenting classes, always with her children present, she seemed to lack trust. She attended parent support groups and was fairly quiet in group activities. However, staff found that she began telling them one-on-one her opinions about the program. As she began to trust the staff, Natalie shared her concerns about relationship problems with her boyfriend and her mistrust of other parents in the group.

Despite a volatile relationship with her boyfriend, Natalie became pregnant. Staff worked with her throughout her pregnancy; Natalie followed through with her prenatal appointments and delivered a full-term baby girl. Natalie was asked to give her baby to her boyfriend's family living in Micronesia. While agonizing about this, she again became pregnant.

Through these difficult times, Natalie trusted staff to help her with many of her needs. Staff helped her move to more permanent public housing. Natalie also started saving money at staff's suggestion. She participated in play group then enrolled in parent support group. She decided to use HRTL for her prenatal care and regularly went in for prenatal appointments. She reported that she preferred to go to HRTL rather than to her obstetrician/gynecologist and felt the change to HRTL was best for herself and her children.

HRTL became a "one-stop shop" for Natalie, so the HRTL team encouraged her to develop a service plan, which she then implemented with the team; it worked well. She followed up on school support for her two older children, identified a care coordinator for her two younger children, and followed through after her family relocated. In addition, Natalie asked HRTL to help her coordinate with other community programs to get additional support with other parents. She now enjoys her time at HRTL and attends the other community programs that meet her children's needs. Natalie and her family, with the assistance of the HRTL staff, are now able to accept a circle of collaborative support, the heart of which is mutual trust.

Principle #3:

Family-centered interprofessional collaboration acknowledges that the development of trust is an integral part of the collaborative relationship.

The following illustrates a family which was distrustful at first but learned to trust the staff and the other families at HRTL through frequent encounters. The staff listened and responded to the family, learning to take their lead to help themselves so that eventually the parent and her children benefited from this collaborative relationship.

(Contributed by Melvin Hayase, the social worker at HRTL.)

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Principle #4: Family-centered interprofessional collaboration facilitates open communication so that families and professionals feel free to express themselves.

The following illustrates how this family learned about HRTL and enrolled in the program. Encouraged by HRTL staff practicing family-centered care, communication was open, and the family and professionals were free to express their concerns and hopes for the future.

(Contributed by Lisa Carlson, the early childhood educator at HRTL.)

Mary, a Samoan mother of three children, was referred to HRTL by Ewa Healthy Start for play group activities for her children (ages five years, three years, and seven months). During her initial telephone conversation with the HRTL staff, Mary informed Lisa, the early childhood educator, that she wanted information on play groups that all three children could attend. Since she and her husband "did everything together," Mary also wanted to know if he could attend the activities and if any other fathers would be present. As part of a 30-day get-acquainted-with-HRTL (intake) process, Lisa provided an overview of the parent support group and Mixed Plate (which combines parenting classes with an early childhood play group). Mary was also given information on other community play groups.

Mary signed up to attend Mixed Plate with her husband and children and said she might like to attend a community play group the next day. Lisa offered to join them for their first visit to the community group (a part of HRTL service coordination), and Mary agreed. The family and Lisa met in the informal atmosphere of that play group the next day. Lisa observed as the children played and listened as the parents shared, gathering information that typically would be gathered in a structured interview with the parents and developmental testing of the children. This more relaxed setting encouraged the family to continue working with Lisa, and the next week they came to HRTL for Mixed Plate.

Lisa, whom the family already knew, greeted them at the door of HRTL and introduced them to other families and staff. Mary joined the class while her husband, Don, stayed in the welcoming room where he played with the children. Don engaged staff in conversation and shared stories about his childhood and his dreams for parenting differently than he had been raised. This getting-acquainted opportunity arose as a result of a thoughtful intake process; it opened communication that respected the family's level of comfort with sharing their concerns and priorities. Concurrently, staff were able to determine that Don's family was eligible for HRTL services.

Following Mixed Plate, Mary discussed her desires for her children. She very much wanted her children to have contact with children outside their extended family and was concerned about their transitions to school. Lisa explained about the play groups and how they would help her children become exposed to other children, educational activities, and materials, all of which would help them adjust to school.

As the family continued their participation in Mixed Plate, more of their family stories unfolded. The HRTL staff created an atmosphere that was open and friendly, where the family shared information at their own pace. They shared their strengths, attitudes, and concerns, as well as issues around relationships, discipline, school readiness, breastfeeding, and many other things of importance to them. Within HRTL's atmosphere of open communication, the family determined the goals they wanted to pursue; moreover, the family-centered intake process encouraged the family to choose the activities which best suited their needs.

HRTL families and staff bring to the Center their diverse cultural backgrounds, values, and beliefs. Families vary in age, composition, and education. Siblings in a household, for example, often may have different sets of parents. Also, extended families are composed of related and unrelated adults and children, all of whom affect the child's development. Such diversity can benefit as well as challenge HRTL staff; they must assume neither that the mother is the primary caregiver (as in most Western cultures), nor that a mother is abandoning her child when she offers her child to her husband's family to raise.

Meet Emma. Emma, who is Portuguese, lives with her two children, the children's father, Ron, and their widowed grandmother, who are Chinese. Emma grew up as an only child; in her family, her father worked and her mother stayed at home. She reports that her father was authoritarian, often verbally and physically abusing both her and her mother.

Emma remembers celebrating traditional holidays and having traditional food as important parts of her upbringing. She believes that her own childhood has influenced her parenting skills, and at times it is a struggle for her not to be like her parents. Emma reports spanking her children when she feels frustrated and "at wit's end." She has a difficult time making her own place in their home; part of the conflict lies with her husband's split alliance between his wife and his mother.

Ron was raised with traditional Chinese values such as honoring his parents and behaving similarly to his own father in his role as a father. For his Chinese-speaking mother, Ron is a cultural bridge for her between Hawaii and China. He believes that his role in their family is to be the provider, and he works long hours. Ron was educated in a Western system and reports growing up being teased for the "funny ways" he did things in school.

Like Ron, Emma was educated in Hawaii; she holds a Bachelor's degree. However, at first Emma didn't understand Ron. In an effort to learn more about him, she studied Chinese cultural values and roles and even took a class about Chinese parenting. She talked with HRTL staff about her desire to understand her husband's culture, especially his relationship with his mother. Through HRTL cultural celebration activities, Emma and her family learned about other families' values and conflicts. At these events, parents share stories of their own childhoods, growing up Hawaiian, Filipino, Chinese, Samoan, Japanese, or in combination. From this sharing, Emma learned about families' differences and similarities. This gave her an appreciation of the differences between herself and her husband and also led her to view these differences as strengths. She has chosen to blend those cultural values that made sense for her and her children.

Principle #5:

Family-centered interprofessional collaboration creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored.

The following illustrates how HRTL created an environment where a couple learned to appreciate their differing traditions and discovered ways to raise their children which honor the cultures of both the mother and the father.

(Contributed by Audrey Ching, project director.)

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Principle #6:

Family-centered interprofessional collaboration recognizes that negotiation is essential in a collaborative relationship.

The following illustrates how a pregnant mother and her family worked with the professionals at HRTL and KMCWC to receive early intervention and follow up care for their daughter.

(Contributed by Dianne Wakatsuki, the nurse practitioner at HRTL.)

Zelda was referred to HRTL in August 1996 by Rural Oahu Family Planning because she needed prenatal care and had no medical insurance. Zelda was a 37-year-old married Filipino woman with limited understanding of English. Her husband received U.S. citizenship in 1995, but Zelda stayed in the Philippines until April 1996. When she came to live with her husband, his health insurance plan enrollment was closed; Zelda was not eligible for coverage until 1997. She was already four months pregnant and unable to make cash payments for prenatal care.

At her first visit to HRTL, Zelda spent time talking with Mel, the social worker, who assisted her in the completion of a Quest (Medicaid) health insurance application. I saw her with the ob-gyn resident for the initial prenatal work-up. Zelda indicated that she was the fifth of nine children. Her history was normal, with the exception of advanced maternal age; her physical exam was within normal limits.

Routine lab tests were ordered for Zelda; her lab results indicated high risk for Down Syndrome, edema, and fetal bradycardia. The physician was concerned about possible fetal abnormalities and ordered additional labs, which indicated possible Cytomegalovirus (CMV) infection. CMV infection can result in extensive fetal damage that can cause severe brain damage, but it can also result in no damage. The infected newborn is usually small and often has other complications. This simple prenatal case became complicated, requiring planning, discussion, education, and negotiation among family members and professionals.

The first step was breaking the news to the family. The physician and I met with the family to discuss test results and implications; Zelda was offered counseling. She was committed to continuing the pregnancy. The language barrier made communication difficult; a relative who could translate agreed to sit in on the counseling sessions.

It was obvious that the whole HRTL team needed to be involved with the family because there was potential for delivery of an infant with multiple needs. The staff was educated about CMV and began making plans for collaborative support. The family met with the HRTL team to negotiate ways the family and Center would work together. The most pressing concern was insurance coverage. The social worker followed up with Quest to get the family enrolled as soon as possible, and Lisa, our early childhood educator, began to work with Zelda to determine how much the mother understood of normal child development. Zelda and Lisa began a plan for future work together, along with the pediatrician. Mel and I continued to counsel and offer support as the family came in for visits.

Throughout Zelda's pregnancy, the HRTL team worked with the family, always mindful of language differences. The family was granted Quest coverage. Prenatal visits were at HRTL, with consultation services provided at Kapiolani Medical Center for Women and Children. On January 30, 1997, Zelda delivered a (4068 gram) baby girl. The infant seemed to be normal and doing well. Follow up lab tests were negative for CMV. Since a heart irregularity, ventricular septal defect, was diagnosed, the pediatrician, family, and I developed a plan of care to provide the optimum health environment. While well-child exams continue at HRTL, the pediatrician will continue exams and counseling regarding cardiac care and "sick" visits. Meanwhile, Lisa will begin developmental screening for the child at HRTL, and Mel and I will continue to provide family support, including follow-up on insurance coverage for Zelda and her infant.

HRTL participated in the Waipahu Ohana Center, which is a community school-based, family oriented partnership between a school (Waipahu Elementary), YMCA (Young Men's Christian Association), Hawaiian Electric Company (the local utility company), Queen Liliuokalani Children's Center, (a social service agency serving orphaned Hawaiian children), State Department of Health (Public Health Nursing Branch and Leeward Family Guidance Center), State Department of Education (Leeward District Office), and State Department of Human Services (Child Protective Services, Home Builders Program).

Most of these agencies have committed to the Ohana Center's collaborative case management system. It entails a written commitment from agency partners to work together to help families through the complex system of health, education, and welfare.

The Alani family was referred to the collaborative case management group by HRTL because of their self-identified need for multiple services. Ms. Alani was concerned about each of her four children. Since she had already developed a trusting relationship with HRTL, Ms. Alani agreed to extend this added coordination of services for her children, James, Jane, Jay, and Kay.

James, her 12-year-old son, was not attending school, unbeknownst to anyone but the school. Although he left home on time daily, he frequently went to his aunty's empty home while the family was at work. Jane, Ms. Alani's 3-year-old daughter, was no longer eligible for early intervention services provided by the Department of Health. She was referred to the Department of Education (DOE) for special education preschool services several months prior, but no one could ascertain the status of that referral. Jay, Ms. Alani's 2-year-old son, had displayed some developmental delays similar to Jane's and was referred to H-KISS (Hawaii Keiki Information Service System, Part H child find service) for evaluation. The family was told that they were already in the system and that the current care coordinator simply had to make a referral for evaluation. However, no one knew who was the family's care coordinator.

Ms. Alani and the collaborative case management team identified the relevant issues for her family and developed a service plan together. The team agreed that: 1) the school would follow-up on the status of the referral to DOE for Jane and the educational alternatives for James. He could not make up lost credits but would not be held back; 2) a care coordinator would be identified as soon as possible, particularly to make the appropriate referral for Jay and possibly for Kay, Ms. Alani's 6-month-old daughter; and 3) since the family was moving, the family would be linked to similar local services in their area.

Principle #7:

Family-centered interprofessional collaboration brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

The following shows that community agencies can work together on behalf of children and families to assure improved services.

(Contributed by Mel Hayase, HRTL social worker.)

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Summary

. . . (A) shared commitment to improve outcomes for children is what can make efforts at collaboration fall into place – not as an end, but as an essential means of working together to improve results.

Schorr, 1995

The development of *Building Bridges* has been a bold attempt to build shared commitment and to improve outcomes for young children at risk and their families. The efforts of HEC and HRTL staff have combined the challenge of meeting the ever-changing requirements of their families with the additional challenges of trying to collaborate interprofessionally and to teach others how to accomplish that. The lessons learned from the work of HEC and HRTL during Year Three will be helpful to others developing interprofessional collaborative programs. The work demonstrated was complex and difficult to describe. This was illustrated by the needs of the families being served, competing needs of staff and partners, and the changes in partnerships (which will be described in Building Bridges, Year Four). HEC and HRTL staff worked hard to be more collaborative and family-centered during Year Three. The new approaches for service delivery for families at environmental risk have demonstrated positive outcomes for children and their families, as shown in the Practice Examples. The work reported here shows ways that families, professionals, and communities have learned to interact that will impact the system of service delivery. In sum, Hawaii's commitment to improved outcomes for young children pulled the pieces of collaboration together into a more cohesive, service-based program.

There were several strong program developments this year. In addition to staff learning to support each other, the training of staff, family members, university students, and community leaders developed. Evaluation efforts increased as medical residents, practicum students, parents, agency workers, and researchers worked to develop and implement outcome-based evaluation models for the HRTL program. Family-centered and community-based efforts increased. Lessons learned from these efforts were shared with others, including university researchers and agency administrations in Hawaii, and reached other projects in Vermont, Oregon, California, and New Mexico. (See Appendix B.)

More changes lie ahead for the staff, children, and families of HRTL. As HRTL moves into Year Four, they enter a new building and a new program era. Child and Family Service (CFS) will be responsible for both program and administration. HEC will continue the training and dissemination components through work with other agencies. HRTL is ever-changing.

These changes look promising. Dr. Rob Welch, President and CEO of CFS, looks ahead to Year Four with anticipation:

> **Cal Sia and the HEC Project have given us a great, great starting point. No one else has integrated the medical community with interprofessional collaboration such as the HEC and HRTL have demonstrated through the third year. We look forward to continuing to develop this model.**
>
> Rob Welch, Interview, 1997

Philippe Gross

Vision isn't enough unless combined with venture. It's not enough to stare up the steps unless we also step up the stairs.

Vance Havner

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Appendix A:

Outline of *Training on Family-Centered Interprofessional Collaboration*

Part I: Family-Centered Care

Section I: Elements of Family-Centered Care

Goals:

- Provide an introduction to the session and address participant expectations.
- Introduce family-centered care and allow participants to personalize its principles.
- Help participants begin to develop techniques to put family-centered care into practice.

Section II: Respecting Family Diversity

Goals:

- Introduce the duality of cultural differences.
- Help participants recognize their biases and how they affect their interactions with families.

Section III: Children with Special Needs

Goals:

- Define children with special needs.
- Specifically address the issue of family-centered care for families with environmental risks.

Section IV: Open Communication with Families

Goal:

- Provide guidelines for communicating with families, especially those with children who have special needs.

Part II: Interprofessional Collaboration

Section I: The Need for Interprofessional Collaboration

Goals:

- Define collaboration.
- Provide a rationale for collaboration.
- Help participants become familiar with a model of an interprofessional collaborative center.

Section II: Philosophies of the Roles

Goals:

- Help participants recognize and gain a better understanding of the roles of professionals from the fields of health, early childhood education, and social work.
- Help participants become familiar with the physician's role in connecting families with other services.

Section III: Integration of the Roles

Goals:

- Explore barriers to collaboration.
- Raise awareness of cross-professional role expectations.

Section IV: Good Communication is Key to Successful Collaboration

Goals:

- Explore barriers to good interprofessional communication.
- Provide opportunities for participants to practice effective communication skills.
- Help participants become familiar with their own communication styles.

Appendix B:
Updates on MCHB Demonstration Projects

National Commission on Leadership in Interprofessional Education (NCLIE)

The NCLIE was initiated in the Fall of 1992 and sponsored for its first three years by the Association of Teacher Educators. Its purpose is to shape a national agenda that will make coordinated, family-centered, community-based, culturally competent services a reality. It hopes to accomplish this by developing the capacity of future leaders in education, health, and human service professions to view the problems of families from a broader interprofessional perspective. Fifty-five representatives from social work, public health, law, criminal justice, psychology, extension, medicine, theology, and education are members of the Commission. The basic criterion for membership is actual involvement in the development, implementation, and evaluation of integrated services and interprofessional education. Now in its second phase of development, the Commission is balancing the number of members it has from each profession so that it will be truly interprofessional.

The NCLIE comes together to share lessons learned and to connect with others who are interested in creating family centered, culturally competent, community based education, health, and human service systems. Each Commission meeting is organized as an "inquiry seminar." At the meetings, multidisciplinary teams present their ideas and case studies of actual programs in a panel format, and participants react to those case studies, share research and other resource materials, and respond to questions identified by the Commission to guide its work.

The Commission has begun to share its ideas and products through national and state meetings of participating professions. Commission meetings have been held in conjunction with the national conferences of the participating professions (e.g., Association of Teacher Educators, Council of Social Work Education). Dialogue has been established within each profession's networks, and concept papers and articles on integrated services and interprofessional collaboration have appeared in some professional associations' publications. An extensive library including over 50 case studies, newsletters, and other descriptive materials of new programs has also been compiled by the Commission.

Last year's meeting of the Commission was held with the International Parent-to-Parent Conference. This event provided the opportunity to strengthen that linkage with families as partners. Discussion focused on what is meant by familycentered education, health, and human service systems.

In addition, Family Voices, a national family organization which participated in this conference, identified clearly their expectations for collaborative, "family friendly" education, health, and human service systems and, from their personal experiences, they defined essential characteristics of effective providers.

The Commission plans to continue its linkage with the International Parent-to-Parent group and Family Voices. In the future, family representatives will be a part of the membership and governance of the Commission.

The most recent meeting of the Commission was held in San Diego on May 8-10, 1997, with the American Academy of Pediatrics' (AAP) CATCH (Community Access to Child Health) National Meeting. The Commission has long sought a broader conversation with pediatricians on the health of children within the community. A precept of the Commission is that a child must be healthy for maximum learning. The child's health is partially dependent on the health providers in the community. CATCH recognizes the power of the community to address child health problems and focuses on supporting and developing leadership at the community level. CATCH reaches out to and informs pediatricians and the community to raise the status of community-based efforts by pediatricians.

The Commission plans to continue its linkage with the AAP and CATCH. Pediatricians, including the Director of the CATCH program, are part of the membership of the Commission. The Commission will continue to interact with the expanding number of universities throughout the country embarking on interprofessional education programs and involved in family -centered, multiple agency collaborative systems.

Higher Education Curricula for Integrated Services Providers

The overall goal of the Oregon project, Higher Education Curricula for Integrated Services Providers, now in its fourth year, is to disseminate the materials developed by the three selected training sites: California State University Fresno, University of New Mexico School of Medicine, and University of Southern California Interprofessional Initiative. Materials have been developed that will cross train students in the various disciplines so that upon graduation they can affect integrated services to the local level. A set of teaching modules from California State University Fresno has been completed and is now available. Similar materials from the other two sites are anticipated in Spring 1998 and will be made available.

A report on the first phase of the project, identifying family-centered, community-based projects around the country that have been successful in applying an integrated service approach that benefits at-risk families, children, and youth is completed, as is a report on selected private foundations and their degree of support for integrated service projects. Two annotated bibliographies which include information on integrated service programs, resource directories and bibliographies, and interprofessional training and education programs are also complete and available.

Project staff will 1) complete a monograph on the grant and its activities including evaluations, 2) publish the last two issues of the bi-annual newsletter, Service Bridges, 3) publish a final addendum to the annotated bibliography, and 4) publish the training materials from the three selected sites. For additional information, please contact Dr. Vic Baldwin, Project Director, Teaching Research Division, Western Oregon University, 345 N. Monmouth Avenue, Monmouth, OR 97361, (503) 838-8794 or 838-8394, fax: (503) 838-8150.

Partnerships for Change (PFC)

Family/interprofessional collaborative practice is one of the approaches that is integral to high quality services for children and families. The overall goal of PFC is to improve services to children with special health care needs and their families by focusing on integrating this approach into the education and practice of professionals.

PFC's efforts to bring an interprofessional focus to university-based programs began in social work with the inclusion of knowledge, skills, and values about interprofessional practice as required competencies for students in field placements. Qualitative interviews with field instructors and student journaling about interprofessional learning provided data to inform PFC products while at the same time contributing to the visibility of the new focus both at the University of Vermont (UVM) and in the community. As interprofessional practice became an interest for students, faculty increasingly requested that PFC provide resources for teaching interprofessional content and included these resources in policy and practice classes. PFC's yearly seminars for students, faculty, and field instructors have also distributed resources and supported the continued development of interprofessional learning strategies. Like other project activities, focus groups with students from different disciplines served a dual role, supplying data for PFC products while bringing information about interprofessional practice to other academic departments, such as physical therapy, nursing, education, pediatrics, speech, and language. PFC also developed and has begun to test a peer consultation model for the interprofessional education of students from different disciplines who are placed in community settings. Education-related products include resources such as a teaching module on interprofessional practice and suggested wording for required competencies in interprofessional practice and policy for students.

PFC is conducting qualitative research with children with special health needs, their families, and the professionals with whom they work in order to describe the role of interprofessional practice and coordination in providing services that are responsive to families' priorities. Data is being analyzed on an ongoing basis; results have been and will continue to be presented in workshops which employ diagrams of families' perceptions of complex service systems as dramatic, visual evidence of the importance of interprofessional practice. PFC has also collected descriptions of programs which demonstrate high quality, family-centered interprofessional practice and conducted related qualitative interviews. The result is the dissemination of recommendations and strategies which can be found in such products as Information Exchange bulletins and the book, Partnerships at Work, which highlight promising community practice.

PFC's partners in the development and dissemination of family/interprofessional collaborative education and practice approaches include children, young adults, parents, and extended family; Federal MCHB, Division of Service for Children with Special Health Care Needs; Family Voices; NCLIE; the Council on Social Work Education; the National Association of Social Workers; the American Academy of Pediatrics, the National Coalition on Family Leadership; the Association of Teacher Educators; VT Department of Health, VT Interdisciplinary Leadership Education for Health Professionals (VT-ILEHP); Parent to Parent of Vermont; UVM students and faculty in the departments of social work, education, physical therapy, speech and language, nursing, and medicine; elementary, middle, and high schools; and community agencies.

Publications available include: MSW Field Education Manual, Revision (Cass, 1995) which includes required interprofessional experiences; Interprofessional Education and Practice: A Selected Bibliography, published by the Council on Social Work and Education and a developing bibliography on family-authored and family/professional co-authored literature; PFC Information Exchange bulletins; Partnerships at Work: Lessons Learned from Programs and Practices of Families, Professionals, and Communities; position papers; a monograph, Family/Professional Collaboration for Children with Special Health Needs and their Families; and training resources.

For more information, contact: Kathleen Kirk Bishop, D.S.W., Project Director, Partnerships for Change, Department of Social Work, University of Vermont, 228 Waterman Building, Burlington, VT, 05405-1156, phone: (802) 656-1156, fax: (802) 656-8565, e-mail: kbishop@zoo.uvm.edu, PFC web page: http://www.ichp.edu/mchb/pfc.

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Interviews:

Alger Foundation: Caroline Oda

CFS: Vicki Wallach, Rob Welch

HEC/HMA/HRTL: Anne Duggan, Dolores Brockman, Joni Choi, Mel Hayase, Lisa Carlson, Audrey Ching, Blanche Butler, Dianne Wakatsuki, Cal Sia, Sharon Taba

KMCWC/UHM: Louise Iwaishi, Lori Kamemoto

Sample Interview Questions:

General

What is your position? What are your primary duties associated with your position?

Please list 5 ways your position helps children and families.

How do you collaborate with HRTL to provide services to families?

What helps or hinders the collaborative process?

In what situations are professionals likely to withdraw from the collaborative process?

Does the collaborative process confuse families? In what ways?

What suggestions do you have to remove barriers to collaboration?

What changes have you seen in the collaborative process since you began work at HRTL?

Building a Shared Vision

How are you involved with the process of change, such as when the vision and mission of HRTL were altered?

Do you feel your recommendations were heard, and were they incorporated?

How has HRTL been successful in accomplishing its mission statements? Select one of the mission statements and cite an example of how your staff has translated it down to a goal, objective, and practice.

Monitoring, Evaluation, and Refinement

What are the tools used for monitoring and evaluation?

How are these tools and their findings used for program refinement?

How are changes in service (structure and function) decided upon and implemented?

Staff Development

What types of staff development activities have been provided?

Are the staff development activities collaborative?

Flexibility and some levels of ambiguity or open-endedness are to be expected in human services. How does ambiguity affect your team performance outcomes? Are leaders ambiguous?

Training

How do training and service delivery fit together in your day-to-day activities?

Why are training and service delivery integral to sustaining an integrated system of care?

What makes a good trainer? (For Trainers: What is valuable to you about being a trainer?)

Dissemination

How does HRTL disseminate lessons learned to local, state, and national audiences? What seems to be the focus of information shared?

What is your role in dissemination? Please name 3 things you have done to heighten awareness about the program.

How does HRTL target its audiences?